RISK MANAGEMENT DIVISION

Department of Administrative & Financial Services
85 State House Station, Augusta, ME 04333-0085

RMD File#

MEDICAL CLAIM QUESTIONNAIRE

Please complete all questions & sign at the bottom

Date of Accident _____ Time of Accident _____ AM PM

Name _____ Home Phone # _____

Address _____ Work Phone # _____

City, State, & Zip _____

Location of Accident _____

To whom did you report this accident? Please give name & telephone number _____

_____

Please give a description of the accident: _____

_____

_____

_____

_____

_____

_____

What is the nature of your injury? _____

_____

Were you treated at the scene of the accident? ☐ YES ☐ NO

If yes, by whom? _____

Did you seek further medical attention? ☐ YES ☐ NO

If yes, please complete the following if applicable:

Physician or Hospital name? _____

Address _____

PLEASE SIGN BOTH THIS FORM AND THE MEDICAL AUTHORIZATION FORM ON THE REVERSE SIDE. RETURN TO THE ADDRESS NOTED ABOVE. ATTACH ANY MEDICAL BILLS PERTAINING TO THIS ACCIDENT. THANK YOU.

I have read and completed this statement and it is correct to the best of my knowledge.

_____ _____

Signature Date

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AUTHORIZATION FOR MEDICAL INFORMATION

PATIENT _____

This authorization, or photocopy hereof, which is unlimited as to time, will authorize you to release to the RISK MANAGEMENT DIVISION, or its appointed representative, all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis.

_____ _____

Signature Date

_____

State Relationship if not the Patient